POSITIVE PSYCHOLOGY CONSTRUCTS AND WELL BEING IN OLDER ADULTS

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Submitted By
Manpreet Ola
Enrollment no: ICG/2015/20483
Under the supervision of
Dr. Roopa Mathur
Professor

DEPARTMENT OF PSYCHOLOGY
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DECLARATION

I, Manpreet Ola have selected a research topic entitled "*positive psychology constructs and well being in older adults"***for my dissertation after care full brief survey of appropriate available literature.**

I will follow the professional ethics for the completion of this research.

Signature of the candidate

Date: July, 2016

Place: The IIS University, Jaipur

Supervisor

Dr. Roopa Mathur

Professor

TABLE OF CONTENTS

Content	Page Number
Chapter I: Introduction	**4-7**
Chapter II: Review of Literature	**8-14**
Chapter III: Methodology	**15-19**
• **Aim of the Study**	
• **Hypotheses**	
• **Sample and Sampling**	
• **Tools**	
• **Research Design**	
• **Statistical Analysis**	
References	**20-26**

INTRODUCTION

Everywhere in the media, newspaper articles, magazines we see that our elders are facing horrible domestic violence, they are mostly neglected by their family members, they are no more taken as essential members of our community instead they are considered to be a burden either on the family members or the society. And all these atrocities which they have to face daily, the pressures of living in this world where they are no more valued makes them prone to suicides, poor mental and psychological well being. All these negative environmental burdens are very damaging for their health. It is really essential especially in India where the population in the age group above 65 years is rising, that proper government policies be implemented, steps should be taken to improve the conditions of our elderly so that they live a healthier and happier lives, after all they are our valued asset. It is also very crucial that we realize that the personal capabilities of older persons are determined by their command over financial resources, health, education, employment and social support, and they are affected not just by vulnerabilities experienced over earlier life but also by the intrinsic process of ageing and by the events that trigger changes during old age. Moreover, older people's capabilities and functioning can also be limited because of the restricting social and physical (external) environment in which they live. Older persons who might otherwise be equally endowed with personal/internal capabilities may still face differing levels of vulnerabilities based on their identity, activity or spatial location. A combination of low personal capabilities and a restricting physical and social environment can therefore hold back older persons from taking advantage of opportunities available to them and impacts their subjective well being.

Self efficacy:

Self-efficacy is a person's feeling about himself that he can perform any work by utilizing his abilities oractions. According to the Bandura (1995), self-efficacy is the belief in one's capabilities in order to perform work in ambiguous or difficult situation. Low self-efficacy promotes negative feelings about one's abilities and responsibility for one's own performance. A high degree of self-efficacy promotes the perception that one isresponsible for one's destiny and

that one can do what one wants to do. Self-efficacy arises from gradual acquisition of complex cognitive, social, linguistic, and/or physical skills through experience (Bandura, 1982).

Optimism:

Scheier and Carver (1985) defined optimism as a set of generalized positive outcome expectancies. According to their conceptualization, people who generally expect that things will go their way and believe that they will have more good outcomes than bad, are dispositionally optimistic.

It is a major construct in positive psychology. There is a positive impact of optimism on physical and psychological health which leads to academic, athletic, political and occupational success.

It affects our personal growth, our sense of purpose in work, our relations with others, our pride in our accomplishments, and our general level of happiness in work (Chiok, 2001).Furthermore, optimists tend to rely more heavily on positive reframing in that they are more likely to reframe adverse situations so as to see their more positive aspects when compared to pessimistic individuals (Schier, 2003). Dispositional optimism thus appears to provide a good foundation for individuals to build a strong sense of self-efficacy in various aspects of their life.

Hope:

Snyder et al. (1991) defines hope as "a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-oriented energy) and (b) pathways (planning to meet goals)." This meaning of hope consists of both the "willpower" (agency) and the "waypower" (pathways). Importantly, considerable research over the past several years indicates it has a very positive impact on academic achievement, athletic accomplishment, emotional health, the ability to cope with illness and other hardships.

Resilience:

Resiliency is viewed "as the capacity to rebound or bounce back from adversity, conflict, failure or even positive events, progress and increased responsibility (Luthans, 2002).Resilience is not a trait that people either have or do not have. Resilience involves behaviors, thoughts, and actions that can be learned and developed in anyone. Resilience is tremendously influenced by a person's environment.

Subjective well-being:

Diener (2006), refers to this as subjective well-being which he defines as " the various types of evaluations, both positive and negative, that people make of their lives. It includes reflective cognitive evaluations, such as life satisfaction and work satisfaction, interest and engagement, and affective reactions to life events, such as joy and sadness. Well-being is thus conceptualized as a construct comprising three components; namely, life satisfaction, positive effect, and negative effect. Life satisfaction reflects a cognitive evaluation of one's life, while positiveand negative affect provide insight into the emotional experiences of an individual's life. Diener (1994) suggests that it is imperative that all these components are examined when evaluating subjective well-being.

Environmental factors:

Social support:

Social support is a concept that is generally understood by intuitive sense, as the help from other people in a difficult life situation. One of the first definitions put forward by Cobb (1976), defined social support as the individual belief that one is cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligations. This concept is strategic in understanding the maintenance of health and the development of mental and somatic health problems, as well as their prevention.

Social support has two separate domains, structural and functional (Cobb 1976). Structural social support is the actual physicality of the support such as frequency of contact with friends or family, voluntary organizations or associations, religious services and other community service. Functional social support includes happiness with such areas as verbal and physical appraisal, tangible help with tasks, communication of helpful information and guidance and social companionship (Cobb 1976; Cutrona 1990).

Health status:

The World Health Organization's definition of health refers to the "complete status of physical, mental, and social well-being." This definition contrasts with early studies where health status was determined via mortality rates (Riedpath, 2003), and chronic conditions (physician ratings and functional ability) (Dempsey, 1947). Recently, perceived health has been used to measure health status (Idler, 1997). Kaplan *et al*. suggested that perceived health held the key to understanding other psychosocial influences on health. This is a simple, direct, and inclusive method, because it is based on the respondent's perceptions (Kaplan, 1983).

Negative life events:

Historically speaking, research on health effects of stressful life events commenced with clinical records of individual reactions to war. Since then researchers have gained interest in this area, to see its impact on our lives, how it influences us etc., objective characteristics of a stressful encounter influence the way people appraise them cognitively as challenges, threat, harm, or loss. Severity, duration, and ambiguity of a stressor, among other characteristics, make a difference when it comes to appraisal, emotions, coping, and outcomes. Over a time the stressors have become varied and wide. Each and every stage of life has a different stressor and has a different impact on us. Loss of loved ones, academic failure, injury, job loss, divorce, and disasters that affect an entire community can be categorized along a number of dimensions, including predictability, controllability, suddenness, and strength of impact, etc.

RATIONALE:

If we look at the work done in the past by various researchers on the geriatric population, it can be clearly seen that the trend is towards seeing the negative factors influencing the lives of the elderly. There has hardly been any research which is emphasizing on the positive aspects of their lives or either emphasizing how can the positive psychological capital impact and influence the subjective well being of the aged. The research studies done using any of these variables is very scarce and scattered, hence through this piece of research work, the aim is to study the positive psychological capital variables (self efficacy, hope, optimism and resilience) and their role in tackling the adverse effects created by negative environmental factors such as health issues, support system, etc., and thus promoting subjective well being of the elderly. The findings of the study will help psychologists look for factors which can enhance the positive mental health in this population and also help the policy makers in implementing policies which can be fruitful for their lives.

Following research problems could be thought of in this area:

1. Do the people in the old age group have enhanced subjective well being?
2. Do the positive psychology constructs such as hope, optimism, resilience and self efficacy have any impact on enhancing their subjective well being?
3. Is there any interaction between these positive psychological constructs, environmental factors and subjective well being for the geriatric population?

REVIEW OF LITERATURE

Positive psychological constructs:

Resilience:

The focus of psychology towards this topic started some 30 years back when developmental psychologists started noticing that the adversities faced by children have an impact on their development, however its importance for the old age started due to the movement of positive psychology (Seligman, 2000). Currently this term is widely used in developmental psychology, life span development, old age, recovery from traumatic events etc. (Bandura, 1997).According to various researchers it is understood as the characteristics of the people and situations that allow them to flourish despite adversity and bouncing back after this adversity (Schoon 2006). Though it has been widely used in the researches with the child and adolescent population, its use in the old age is quite limited (Baltes&Baltes 1990), though whatever researches have been published with this population have primarily focussed on the psychological rather than the sociological factors such as social support etc. (Mayer et al 1999). Elderly people are considered psychologically resilient when they do not succumb to adversity, but rather exhibit the capacity for successful adaptation characterised by managing stressful events, or recuperating previous or baseline levels of objective or subjective well-being after exposure to an adverse event. In the face of adversity, the elderly are able to change its meaning, reduce the level of danger caused by stressful events, reduce their exposure to such events, reduce negative reactions, maintain positive self-esteem and self-efficacy and create opportunities to revert the effects of stress (Hardy, 2004).

Schröder-Butterfill (2012), and also Sabates-Wheeler and Devereux (2008), emphasized that the concept of resilience, when seen from a gerontology perspective, needs to be seen beyond the individual level, and explored how higher overlapping and interrelated levels of resilience (referred to as social resilience) make sense for the lives of older people which is resilience at the levels of individuals, households, families, neighbourhoods, communities and societies (Wild et

al. 2013), It can be argued that this is the most relevant way to conceptualize resilience and social empowerment in old age, given the importance of communities, households and neighbourhoods in the experiences of older people, and also in avoiding putting onus solely on weak older people.

Wild and colleagues (2013) also suggested that models of resilience in later life need to distinguish between different 'areas of life' where resilience may be occurring or weakened; these different forms of resilience may or may not overlap or interact. For example, an older person may be less financially resilient, but they might still enjoy community support, they may also be psychologically resilient to compensate for financial shortcomings. In addition, different levels (micro, meso and macro) and areas (financial, cultural, etc.) may operate interactively.

People high on resilience are also seen as more optimistic when confronted with situations of adversities which in turn leads to a higher psychological well being(Rutter, 2006). There has been ample research that has shown the cyclical relationship between resilience as a contributor to positive experiences and vice versa. Studies show that people high on resilience not only trigger/perpetuate positive emotions like optimism, creative exploration, humor effective coping and relaxation within themselves but also evoke positive emotions among others. (Werner& Smith, 1992;).

Self efficacy:

The concept of self-efficacy which relates to judgment people make concerning their ability to execute behaviour relevant to a specific task or situations. It refers to the confidence in once ability to behave in such a way or to produce a desirable outcome (Bandura, 1977). Self efficacy makes a difference in how people feel, think and act. Self efficacy pertains to optimistic belief about being able to cope with a variety of stressors. People with high self efficacy choose to perform more challenging and difficult task. In terms of feeling low level of self efficacy is concerned with depression, anxiety and helplessness. People with high level of self-efficacy approach life with a can do attitude that allows them to see challenges as problems to be solved instead of threats that must be avoided. They also set appropriately challenging goal for

themselves and maintain a strong commitment to those goals. People with strong self efficacy enjoy life because they are highly engaged. When they encounter stressful situations their belief in their ability to manage situations to their benefit allows being self confident.

Hope:

In the late 20th century, theoretical and scientific interest in the concept of hope has developed among investigators and clinicians in psychology, medicine and nursing. Although there are a variety of conceptualizations of hope, there has been agreement on the essential characteristics of the concept. Hope is one of the factors in coping, is future oriented and considered to be multidimensional by most researchers. Synder is most closely associated with the research and conceptualization of hope construct. Snyder (2002) gave hope theory. Hope theory also begins with viewing goals as the central organizing component of human behavior (Snyder, 2002). Hope in this model is primarily a cognitive construct that consists of two parts. If goals direct people's behavior, to reach them successfully people must have the capacity to generate *pathways.* Generating pathways is not sufficient to attaining goals, however, people also need to have confidence in "the perceived capacity to use one's pathways to reach desired goals" (Snyder, 2002). In a study specifically related to hope in older adults, Wrobleski and Snyder (2005) found that in community-dwelling older adults, “higher hope related to greater life satisfaction and better perceived physical health”. Findings from their study indicate that, although the high-hope older adults did not enjoy better health or more social support than their peers, the older adults high in hope were able to continue striving toward their goals and felt satisfied with their lives. Based on the reciprocal nature of hope theory, high-hope older adults are likely able to exhibit more flexible goals which allows for easier adaptation under changing life circumstances (Wrobleski& Snyder, 2005). Researchers have found individuals who ranked higher in overall hope to report being able to deal with stress and distressing feelings more effectively, have greater well-being, better ability to function in different domains of life, and have fewer psychiatric symptoms than those with lower overall hope (Irving, Snyder, Cheavens, Gravel, Hanke, Hillberg, et al., 2004).

Optimism:

Scheier and Carver (1992) proposed that optimism led to individuals' ability to preserve in goal-directed behaviors and was the most influential predictor of individuals' behavior. In other words, optimists are people who, even when faced with obstacles to their goals, continue to believe that their goals can be accomplished and maintain effort toward attaining those goals they consider valuable. This presence of a positive disposition has been shown to provide a significant benefit for positive aging in older adults. The results of a study of optimism and health behaviors in older adults suggested that regardless of actual physical health, optimists rated themselves as being in fair or poor health five times less than did pessimists. In addition, results indicated a strong relationship between optimistic outlook and healthy behavioral choices (Steptoe, Wright, Kunz-Ebrecht, &Iliffe, 2006).

Recent studies have found an inverse correlation between optimism and depressive symptoms (Chang, 2001) and also between optimism and suicidal ideation (Hirsch,2007). As such, optimism seems to have an important moderating role in the association between feelings of loss of hope and suicidal ideation (Hirsch,2006). In relation to this, Van der Velden *et al.* (2007) have recently studied the association between 'dispositional optimism' and depression in victims of a natural disaster. The results of this research show that compared to optimists, pessimists nurtured little hope for the future and were more at risk for depressive and anxiety disorders, with subsequent impairment of social functioning and quality of life. The role of optimism in the quality of life has also been investigated in depressive disorders emerging in patients suffering from somatic pathologies, (such as acute coronary syndrome, for instance) in which a significant inverse correlation was found between dispositional optimism and level of satisfaction in life on one hand and depressive symptoms emerging after the cardiovascular event on the other hand (Steele, 2004). From the early studies of Scheier *et al.* (1986), a significant positive relation emerged between optimism and different aspects of life, such as coping strategies focalized on the problem, looking for social support and emphasis of the positive aspects of the stressful situation. There is evidence that optimistic people present a higher quality of life compared to those with low levels of optimism or even pessimists (scheier, 1992). It has been demonstrated that in the presence of severe pathological conditions, optimistic patients adapt better to stressful situations compared to pessimists, with positive repercussions on their quality of life.

In another research it was seen that positive emotions are essential to overall well-being, and that good mood, optimism and satisfaction with one's life are vital aspects of a healthy personality

Avia (1997). Marshall et al. (1992) reported optimism to be highly associated with positive affect, and Peterson (2000) refers optimism to be linked to good mood. As indicated earlier optimism may be defined as a generalized positive expectation for the future (Scheier& Carver 1985; Scheier et al. 1994). Due to the positive relationships between (dispositional) optimism and many physical and psychological outcomes (Scheier& Carver, 1992).

Environmental factors and its impact on subjective well being:

Environmental factors and resources influence the extent to which an older person can maintain subjective and emotional well being. Environmental factors include: lack of opportunities to meet people, living arrangements, negative life events and diminished financial resources.

Negative life events:

It is argued that each critical episode has its unique demands, be it physical, social, role, or task, that specifically tax the individual's coping resources, thus triggering a particular stress response. Negative life events that are common among older persons, such as retirement, widowhood, death of friends, and relocation can cause people to lose long-standing social networks, thus inducing loneliness and hence impact overall well being of an individual. Winter et al. (1999) stated that individuals still suffer from the consequences of divorce or marriage long after the event and do not return to their original level of happiness. Easterlin (2006a) also reported that "adverse health changes have a negative and lasting effect on subjective well-being".

Kumar, Rastogi, and Nigam (1996) also came to a similar conclusion by analyzing the number and severity of life events in a sample of *peptic ulcer* patients. Compared to matched controls, ulcer patients reported a significantly higher number of events and greater severity.

Social support:

The importance of different types of social networks on health and functioning has been a significant theme in sociology, gerontology and epidemiology research.

Social relationships are significant for health, and both social networks and social support influence mortality and morbidity (Cohen &Syme, 1985). Among the elderly, quantitative or qualitative aspects of social ties have been found to be related to mortality (Seeman et al. ,1993) and well-being (Berkman, Leo-Summers &Horwitz 1992). These researchers suggest that having

more extensive social ties and interactions reduces the risk of developing activity of daily living (ADL) disability and increases recovery from ADL disability. Similarly, Zunzunegui, Gutierrez-Cuadra, Beland, Del Ser and Wolfson (2000) indicated that elderly men and women with few social ties, poor social integration, and social disengagement were at greater risk of cognitive decline.

Informal support generally refers to unpaid help given by family, friends, and neighbors (Novak, 1997). However, it is clear that informal support is extensive and can take many forms, including advice, affection, companionship, helping older family members with transportation and nursing care (Kane &Penrod, 1995). Informal support has been held to play a significant role in providing instrumental support (e.g. communications of affection) to older persons, which can involve increasing an older person's self-esteem, competency, and/or autonomy. The informal support networks of older persons are very important as these networks give residents a sense of belonging. These networks provide older persons with the opportunity to spend time and share activities, with others and the absence of these can contribute to loneliness and depression.

Health status:

Health is a multi-dimensional concept that is usually measured in terms of: 1) life expectancy (using international comparisons); 2) healthy life expectancy; 3) years of potential life lost (using international comparisons); 4) physical and mental illness; 5) self-rated health status; 6) limitation of activity; and 7) chronic disease prevalence {Healthy people 2020, (2015)}. More recently, self-rated health status has been used as a measure of how an individual perceives his or her health by rating it as excellent, very good, good, fair, or poor. Several studies have been developed to examine the importance of health quality in old age. The physiological process of aging is marked by a decrease in motor skills, reduced strength, flexibility, speed. Perceived health status is a reliable and valid indicator for general health and many morbidities and mortality In older adults (Idler, 1997).

Subjective well being:

Well-being as a construct in recent times has sanctioned a flourishing place in the field of psychology and social sciences (Huppert, 2005; Layard, 2005). A study by Kasser and

Ryan(1996) showed that enhanced subjective wellbeing was positively correlated with individual personal goals being more intrinsic in nature. Similarly people high on subjective well being have attritional styles that are more self enhancing than those who are low on subjective well being (Ryan and Deci,2001).The concept of subjective well being holds importance and is a major goal in the lives of individuals (diener 1999) as it not only focuses on strengths, resources, problems and needs but provides a comprehensive picture of health rather than the traditional biological attribution of health.

According to Global Age Watch Index there are four domains of well-being for older persons:

- Financial security, using indicators on the pension income beneficiaries ratio, older people's incomes or consumption relative to the rest of the society, and poverty risk among older people;
- Health status, using life expectancy at 60, healthy life expectancy at 60, and psychological well-being as indicators of physical health and mental well-being;
- Employment and education among older people as a proxy for the coping attributes of older people, given that lacking these attributes makes them more vulnerable; and
- Enabling environments, using indicators pertinent to enabling age friendly attributes of the societies in which older people live—they correspond to societal resilience in the discussion above.

A review of Glaser et al. (2009) on life course influences and well-being in later life points to three domains of the well-being of older persons: poverty and low income, health and social support. Studies identifying other triggers have shown that traumatic events earlier in life are adversely related to health outcomes in middle and older age (Kuh et al. 2002, Krause et al. 2004). These trigger events include parental divorce, death of a child, experience of a traumatic or life-threatening injury, and becoming orphaned during childhood. For example, Krause et al. (2004) found that exposure to a series of traumatic life events across the life course (including unemployment experiences of parents, death of child, etc.) is associated with worse health at older ages. The same study showed that the relationship between traumatic experiences during youth and middle age and current health status is strongest among those aged 65 or more.

METHODS

Aim:

1. To study the impact of positive psychology cluster variables in mediating the relationship between negative life events and subjective well being.
2. To investigate the effect of positive psychology cluster variables in mediating the relationship between social support and subjective well being.
3. To explore the influence of positive psychology cluster variables in mediating the relationship between health status and subjective well being.

Hypotheses:

H1: The positive psychology cluster will fully mediate the relationship between negative life events and subjective well-being in older adults.

H2: The positive psychology cluster will fully mediate the relationship between social support and subjective well-being in older adults.

H3: The relationship between health status and subjective well-being in older adults will be fully mediated by the positive psychology cluster.

Variables:

Predictor variables: Positive psychology cluster (hope, optimism, resilience and self efficacy); negative life events, social support, and health status

Criterion variable: Subjective well being

Sample:

The sample will consist of at least 100 older adults (both males and females) living in Rajasthan and around using, Purposive Sampling procedure. The participants will be selected according to the following criteria of inclusion and exclusion.

Inclusion Criteria

- Minimum age of participants should be between the ages of 65- 85 years.
- Participants should be married.
- Spouses of the participants should be alive.
- Participants should have atleast one child.

Exclusion Criteria

- Individuals who are not fluent in English or Hindi.
- Participants who are divorced or widowed.
- Participants living with family members other than their spouses.
- Participants suffering from any psychiatric illness.
- Participants suffering from any physical handicap.

Design:

This study would make use of causal research design.

Measures:

Personal Data Sheet: To record relevant personal information of the participating individuals this will be inclusive of age, gender and marital status.

Informed Consent: To seek the willingness of the participant.

Hope: The concept of hope will be measured using The Trait Hope Scale developed by Snyder, Harris, Anderson, Holleran, Irving, Sigmon, et al. (1991). This is a 12-item instrument consisting of eight hope statements and four filler statements scored on a Likert-type scale; both pathways and agency thinking are assessed. The Trait hope scale measures the dispositional, or trait, hope of an individual rather than looking at hope in terms of an individual's current state hope. In the original study, internal consistency coefficients ranged from .74 to .84, and test-retest reliability was .85 after three weeks and .73 after eight weeks. The Trait Hope Scale also correlated highly with other commonly used scales measuring similar positive outcome constructs (Snyder et al., 1991).

Optimism: The concept of optimism will be assessed using the revised version of the Life Orientation Test (LOT-R) developed by Scheier, Carver, and Bridges, 1994. The LOT-R is a ten-item instrument consisting of six optimism items and four filler statements that are scored on a Likert-type scale ranging from 0 (strongly disagree) to 4 (strongly agree). The coefficient alpha was reported by the authors as .78, and the test-retest reliability was .68 after four months and .79 after 28 months (Scheier, Carver, & Bridges, 1994).

Self-efficacy:The concept of self-efficacy was measured using the New General Self-efficacy Scale developed by Chen, Gully, and Eden (2001). This 8-item scale improved on the most widely used Self-Efficacy Scale previously developed by Sherer, Maddux, Mercandante, Prentice-Dunn, Jacobs, and Rogers (1982). The newer scale improved has been shown to have higher construct validity with fewer items and high reliability. Participants completing this scale were asked to rate, on a 5-point scale from strongly disagree to strongly agree, the extent to which they agree with a series of statements related to how confident they are in their own ability perform effectively across a variety of situations. Test-retest reliability coefficients ranged from .62 to .66 in the original study. Results of the original study also provided evidence for better construct and content validity than previous measure of self-efficacy (Chen et al., 2001). The coefficient alpha for the present study was .93, suggesting excellent internal consistency.

Resilience: The concept of resilience will be measured using the Resilience Scale developed in 1987 by Wagnild and Young. This scale consists of 25 items and was developed using a sample of older women. Item responses are scored on a 7-point scale indicating the degree to which

participants agree or disagree with statements about their personal views of themselves. The original study demonstrated a coefficient alpha of .91 and test-retest reliability coefficients ranging from .67 to .84 (Wagnild& Young, 1993).

Social Support: The functional and structural social support of participants will be measured using the 19-item MOS (Medical Outcomes Study) Social Support Survey developed by Sherbourne and Stewart in 1991. The concept of structural support simply refers to the actual number of people in an individual's social support system. This type of support is measured on the survey using a single-item question about the number of close friends and family members the participant has. The specific areas of functional support measured by this survey are emotional/information support, positive social interaction, affectionate support, and tangible support. For the functional support items on the survey, participants are asked to rank a variety of statements about available social support in terms of how often it is available to them; items are scored on a 5-point scale from "None of the Time" to "All of the Time." the test-retest reliability coefficient for the total survey was .78 (Sherbourne& Stewart, 1991).

Negative Life Events: it was assessed using the Modified Louisville Older Persons Life Events Survey which is developed from the original Louisville OlderPersons Life Events Survey (LOPES) assessed 54 life events over the course of the year (Murrell et al., 1984). To decrease the survey time, few items will be omitted and individuals will only be asked about events in the past three months. The summary score ranges from 0 to 9 with higher scores representing a greater impact of the event.

Physical Health Status: Information about the perceived and actual physical health of participants will be acquired using Ware and Sherbourne's (1992) MOS 36-item short-form health survey. It wasdesigned for use in clinical practice and research, health policy evaluations, and general population surveys. The SF-36 includes one multi-item scale that assesses eight health concepts: limitations in physical activities because of health problems; limitations in social activities because of physical or emotional problems; limitations in usual role activities because of physical health problems; bodily pain; general mental health (psychological distress and well-being); limitations in usual role activities because of emotional problems; vitality

(energy and fatigue); and general health perceptions. From these items of perceived general health and physical health will be used for the study.

Life Satisfaction: The life satisfaction component of participants' well-being will be measured using The Satisfaction with Life Scale by Diener, et al., 1985; it is a 5-item scale designed to measure global cognitive judgments of one's life satisfaction. Participants indicate how much they agree or disagree with each of the 5 items using a 7-point scale that ranges from 7 strongly agree to 1 strongly disagree. test-retest reliability of the test is 0.82 and the internal consistency of the test is Chronbach's alpha 0.61 - 0.89.

Positive and Negative Affect: The positive and negative affect components of participants' subjective well-being will be measured using the Positive and Negative Affect Schedule (PANAS) developed by Watson et al. (1988). Items are ranked on a 5-point scale from "very slightly" to "extremely." Test-retest reliability coefficients for the positive and negative affect scales were .68 and .71, respectively (Watson et al., 1988).

Procedure:

The study will be conducted in two phases, in the first phase participants will be selected according to the criteria of inclusion and exclusion. In the second phase measures of the study will be administered on the selected sample, in a group setting.

Data Analysis

Data analysis will be done using the Statistical Package for Social Sciences (SPSS) and AMOS. The statistical measures to be used include correlation and path analysis.

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